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For information

Summary of mid-term reviews and major evaluations of country programmes

South Asia region

Summary

The present report was prepared in response to Executive Board decision 1995/8 (E/ICEF/1995/9/Rev.l) which requested the secretariat to submit to the Board a summary of the outcome of mid-term reviews (MTRs) and major country programme evaluations, specifying, *inter alia*, the results achieved, lessons learned and the need for any adjustment in the country programme. The Board is to comment on the reports and provide guidance to the secretariat, if necessary. The MTRs and evaluations described in the present report were conducted during 1998.

Introduction

1. Two mid-term reviews (MTRs) were conducted in South Asia during 1998, for the programmes of cooperation in Afghanistan and Bangladesh. Two major evaluations are reported, a region-wide evaluation of UNICEF support to universal salt iodization (USI) and an evaluation of community responses to sanitation risks in Pakistan. The USI evaluation is summative, i.e. the pilot and exploratory phases of USI programming have largely been completed and the programme is relatively stable and mature. The intended primary users are programme partners at the national level, the UNICEF Executive Board and donors. The Pakistan evaluation is more formative in so far as it is meant to contribute to the programme development process. The primary intended users are programme stakeholders at provincial, district and village levels.

Country mid-term reviews

Afghanistan

2. Preparations for the MTR began in October 1997. Reviews of the water and sanitation programme and the vaccine cold chain took place with the assistance of many of the programme stakeholders. The MTR took place in April 1998 and included regional office and headquarters staff, colleagues from other United Nations agencies, non-governmental organizations (NGOs), donors and Afghan counterparts. Afghanistan authorities did not take part due to the political situation. In October 1998, a

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forward-looking planning exercise for the next country programme (2000-2002) was held. Programmes are being developed that will address the challenges in survival, development and protection.

3. **The situation of children and women.** The under-five mortality rate (U5MR) is estimated to be 260 per 1,000 live births. United Nations models predict the maternal mortality ratio to be 1,700 per 100,000 live births. In 1996, 12 per cent of the urban population had access to safe drinking water; 25 per cent of urban and 8 per cent of rural households had access to sanitary excreta disposal. The literacy rate is estimated to be 27 per cent for men and 6 per cent for women; and 32 per cent of boys and 8 per cent of girls are thought to attend primary school.

4. **Achievements and constraints.** The overriding constraint to the programme has been the civil war. Staff security considerations limit access to large portions of the Afghan population. Few professionally qualified Afghans remain in the country. For most of the country programme, UNICEF support has been absent in three of eight regions. Mindful of the constraints, achievements in the country programme can be reported.

5. Support to child immunization services (the expanded programme on immunization (EPI)) is by far the largest component of the programme as a whole. It has been strengthened with the establishment of a management structure at regional and provincial levels, allowing a service presence in 80 per cent of districts. EPI demonstrates that at least one half of the children in the country can be reached with some sort of health service if enough resources are brought to bear. This success is a result of a broad coalition of partnerships. Data from routine reporting suggest that EPI coverage for measles has increased from 14 per cent of children under five years old in 1994 to 57 per cent at the end of 1997. The 1996 multiple indicator cluster survey (MICS) confirmed high rates over a wide geographic area, with a reported 47 per cent of children 12-23 months old vaccinated against measles. Health partners participated fully in the push for polio eradication, and survey results showed between 64 and 87 per cent coverage with at least one dose of oral polio vaccine (OPV) in selected provinces in 1998. This is a welcome result in follow-up to the 1996 MICS that reported coverage with three doses of OPV at less than 10 per cent of children surveyed. Vitamin A supplementation was combined with the polio campaign.

6. The community education and development (CED) programme reached over 1,000 communities, helping to provide safe drinking water using low-cost technologies. Sanitary latrines were provided for 930 families, and 1.5 million people were reached with hygiene/sanitation messages through an oral rehydration therapy, sanitation and hygiene campaign.

7. Implementation of the education component of the programme was constrained by the Taliban ban on formal education for girls imposed early in 1995. UNICEF suspended assistance to formal education in November 1995. Where girls are not discriminated against, supplies and teacher training have been provided.

8. Through the British Broadcasting Corporation/Afghan Education Drama (radio drama education programme), UNICEF has advocated for non-discriminatory education, improved health and sanitation practices, and attention to child trauma. UNICEF has supported the rehabilitation of mine victims, women's employment in the north, psychosocial trauma counselling in Kabul, and studies on the impact of war on children and on working children.

9. In the first survey of national scope since the 1970s, the 1996 multiple indicator baseline survey generated national and focus district data. Data were collected on 66,596 people in 11,750 households in 96 clusters. The deterioration in security has, so far, precluded a planned follow-up survey of national scope.

10. **Assessment of programme strategies: lessons learned.** A clear message was given that others were looking to UNICEF to take a firm, principled stand with regard to the policy that education should only be supported where girls are not discriminated against. Its lead was also requested in the areas of safe motherhood, gender mainstreaming, data collection on the rights of children and women, the development and maintenance of a database on the situation of children and women, and advocacy for children's and women's rights.

11. The aid community must develop a longer-term perspective on education. UNICEF needs to develop more focused and visible activities. Support to home schools as well as schools in camps for displaced persons proved successful. A low-cost packaged education programme is needed for rapid deployment to any area where the potential for educational provision exists.

12. The area-based strategy for the CED programme has been too narrowly defined, limiting water and sanitation or education activities to specific areas only, and not integrating health. The strategy will be modified to achieve greater programme convergence in selected areas mainly through the increased integration of health and nutrition components.

13. Expanding current partnerships could yield significant benefits. For example, pharmacists and private practitioners could be invited to become partners in the health programme. Increased cooperation between United Nations agencies is envisaged through the adoption of a United Nations assistance strategy. This cooperation, together with closer collaboration with NGOs, will become ever stronger as common policies and operational strategies develop, e.g. a shared vision for education in Afghanistan and the standardization of handpumps to enable a sustainable maintenance system.

14. UNICEF will expand support to safe motherhood and nutrition activities. In order to reach more girls and women, UNICEF will train more female health staff than has been the case in the last country programme. The initiation of an innovative psychosocial trauma programme for Afghan children has shown promise. The initiative will be continued and expanded to include traumatized women.

15. There is a need for more staff, especially international female staff, to be based inside Afghanistan than has been the case in the programme so far.

16. **Country programme management plan (CPMP).** Based on the recommendation of the MTR and a subsequent feasibility analysis, the UNICEF Afghanistan country office was moved from Peshawar to Islamabad in August 1998. The new location enables more effective coordination with other United Nations agencies as well as cost savings. Human resources issues represent a major focus of management attention; in particular, the small number of international staff remaining in Afghanistan has increased substantially the burden on the national staff. The movement of national and some international staff is restricted under the edict that Muslim women are required to travel only with their husband or elder brother. The conflict has had a significant impact on the operations of sub-offices; most notably, the experience and continuing threat of looting requires a flexible approach as well as better coordination with the United Nations system. Additional budgetary provisions need to be made for increased costs of security organized by the United Nations and for trauma counselling for staff.

17. **Development of the next country programme, 2000-2002.** Because of the postponement of the MTR to 1998 owing to circumstances in Afghanistan, the review provided the basis to initiate preparation of the new country programme (2000-2002). As a country note is not required for a three-year programme, it was decided to highlight key MTR recommendations that set out the major directions and priorities for the next country programme. The United Nations Strategic Framework for Afghanistan will inform the structure of the programme. The overall goals of this framework are to facilitate just and sustainable peace through mutually reinforcing political and assistance initiatives.

18. A new programme structure is being developed, with activities grouped in three categories: those related to the survival of children and women; those related to their development; and those related to the rights of children in need of special protection. These will be supported by an advocacy and communications strategy, and gender mainstreaming, capacity-building and community-based activities. Programme-wide, the foundation on which to build will be the positive values of Afghan culture, encouraging children and women to promote peace and respect for human rights.

19. The objectives of the advocacy and communication strategy will be to place and keep children and women high on the political agenda and to strive to ensure that children have a "first call" on resources allocated to Afghanistan by the international community. Advocacy will focus on: the rights to quality education for all children; child health; female literacy; and the protection of children affected by armed conflict. Information and media relations will maintain links with and service international media and the donor community with timely, quality information. Programme communication will expand the use of existing avenues for reaching communities in an environment where common communication channels, television, films, music and pictures are almost totally banned.

20. An integrated primary health care (PHC) approach will be adopted to support the survival of children and women. There will be increasing reliance on community structures to complement fragile public services. Collaboration will be increased with the private sector, which currently provides 60 per cent of health services at the periphery. Priority will be given to improving the quality of child health interventions. The basic infrastructure established for immunization will be transformed into expanded health units. The safe motherhood interventions initiated in three provinces over the past two years will be consolidated.

21. Nutrition promotion, including growth monitoring, will be integrated into water and sanitation and education activities. The distribution of vitamin A capsules during immunization sessions will continue. Subject to a return of peace, support will be expanded for iodization of the three major rock salt plants in the north. Safe water supply will be an integral part of PHC interventions, with an increased focus on sanitation and hygiene.

22. Survival rights will be further promoted through policy formulation and enhanced capacity-building and community-based activities. Focus provinces and districts will be selected for a phased implementation of cross-sectoral activities. Simple home-based records and registration of newborns will be supported, and life skills education will be promoted.

23. With regard to development rights, UNICEF will continue to work to coordinate efforts by the aid community to develop policies and strategies in education. Where possible, UNICEF will provide support to increase access, improve quality and strengthen capacity in primary education. Interventions will be designed with a long-term perspective to fit into an eventual unified education system in Afghanistan. Women will receive information about health, hygiene and other life skills areas. Written materials on these subjects will help to support the maintenance of functional literacy. A first line of action will be to assess the current situation and review lessons learned. The lack of attention to adolescents by aid programmes to date is recognized, and creative initiatives are being explored.

24. Support for protection will encompass advocacy, action-oriented research and programme delivery. The trauma programme for children will be expanded to include widows, female-headed households and orphans. It will maintain an urban focus with regard to working children, and aim at reaching agreements with employers on minimum working ages and hazardous employment. More broadly, support will be given to rights awareness training with selected partners and networks in civil society. Such activities will support United Nations monitoring of violations of children's and women's rights. Drawing lessons from the Graça Machel study, an area of special concern will be child soldiers. Non-discrimination, particularly regarding minority children and women, will be another important area for advocacy and monitoring. UNICEF will maintain engagement with the Afghan diaspora in Pakistan to pursue rights awareness training and monitoring of rights violations.

Bangladesh

25. The MTR for the 1996-2000 Government of Bangladesh/UNICEF programme of cooperation began in July 1997 with the preparation of project and programme reviews. External reviews were commissioned for some projects, the situation analysis was updated, and an evaluation of EPI and an assessment of the water and environmental sanitation sector by the Department for International Development (United Kingdom) were appraised. In August, a programme audit was conducted. These activities led to the review in October 1998, chaired by the Chairman of the Joint Government/UNICEF Advisory Group. Over 100 officials from the Government, NGOs, donors, United Nations partners and representatives from the UNICEF Regional Office for South Asia and headquarters participated.

26. **The situation of children and women.** The 1998 *Human Development Report* ranked Bangladesh 147 out of 174 countries on the human development scale. The average per capita income is estimated at $261. In-flows of foreign aid are declining. Foreign aid loans accounted for 44 per cent of the annual development programme in 1990-1995, down from 72 per cent in 1973-1978.

27. U5MR is estimated to have declined from 151 per 1,000 live births in 1990 to 112 in 1997. The nutritional status of children has not improved appreciably since the beginning of the country programme. Fifty-five per cent of children under five years old were stunted in 1996/1997. Fifty per cent of the population have no access to health care, while existing facilities remain underused.

28. Local-level disparities notwithstanding, Bangladesh believed it had achieved near universal coverage of safe water. Recently, however, a series of surveys have discovered varying levels of arsenic contamination in groundwater in 34 out of 64 districts. This is a public health issue of serious concern for which mitigation measures need to be strengthened. Improvement of sanitation coverage, currently 40 per cent, is a principal programme challenge.

29. There was an increase from 60 to 81 per cent in primary education net enrolment between 1990 and 1997. There has been significant improvement in female enrolment. The girl-boy enrolment ratio has gone from 34 girls/66 boys in 1980 to virtual equality in 1997. The primary school completion rate increased by almost one half between 1990 and 1997. The Government is now focusing on improving the quality of basic education as the primary challenge.

30. The economic and social rights of children and women living in urban slums are the least fulfilled. There are almost 7 million children in the labour force, many of them living in slums. Child labour is growing at a higher rate (4.5 per cent per annum in the last decade) than child population growth (3.07).

31. About 14,000 women die annually due to pregnancy and birth-related complications. Only one quarter of married women of reproductive age receive antenatal care. Only 5 per cent of births take place at health

facilities. Less than 5 per cent of women with obstetric emergencies receive appropriate care. This is exacerbated by two principle factors: caretakers of women are often slow to respond when an emergency arises; and most women are malnourished. Estimates of the number of HIV/AIDS positive cases vary from 56,000 to 208,000. The threat from these diseases is acute in view of the absence of facilities for detection and treatment. The high level of violence against women, including rape, physical abuse and mutilation, has recently been highlighted.

32. **Achievements and constraints.** The MTR found notable achievements in the country programme. These included important communication activities, including a major campaign to address the low oral rehydration salts use rate of 39 per cent; a sophisticated goals monitoring system providing information on trends in key indicators; high quality technical assistance provided to the World Bank-funded Integrated Nutrition Programme; innovative follow-up to the recommendations of the United Nations Committee on the Rights of the Child to the Government of Bangladesh, including wide dissemination in-country, and a subnational mobilization campaign; over 80 per cent of households consuming iodized salt; an EPI programme, which, although showing declining coverage in recent years to one half of the target age group fully immunized, still remains an example to the region; and successful national immunization days against polio which incorporated vitamin A supplementation.

33. Child labour issues are being addressed through innovative approaches that provide non-formal education for children. The Intensive District Approach to Primary Education, with its emphasis on multiple ways of teaching and learning, has enormous potential. The urban basic services project set-up 125 urban development centres providing a range of services for the poor. The Chittagong Hill Tracts is one of the most disadvantaged areas. Some 1,700 community development centres have been established, benefiting 250,000 people and serving as learning centres for 42,500 children. A programme innovation to address the issues of violence against women has been to discuss and act upon the issue in the course of activities related to the maternal mortality reduction programme.

34. The country programme strategy includes a large element of evolving pilot approaches. With the programmes maturing, the MTR recognized that it is now time to develop a consensus among programme stakeholders to clarify objectives and approaches, particularly for the pilot projects. The MTR called for their expansion if they were judged successful. Wide consensus that a programme truly is successful requires good evaluation.

35. The problem of arsenic in the water supply in parts of the country has also emerged as a major constraint to reaching the goal of universal access to safe water. A number of actions have been initiated to address this problem. Funds were provided for a 1997 national survey of water sources which included 19,000 individual tests of water samples. UNICEF procurement services facilitated the importation of kits from India for the survey, and training was provided to engineers in the use of the kits. Since 1997, proposed sites for new pumps are tested for arsenic before sinking a well. In-depth hydrogeological investigations are being supported to supplement the survey. UNICEF staff have been involved in developing the design specifications for a kit to be produced by Bangladeshi manufacturers. A health information brochure has been developed which is distributed to the public in areas where engineers find wells to be contaminated. A comprehensive multi-media communication package is currently under development. Training is being provided to promote and develop rainwater catchment and pond water filtration systems. Staff have also been involved in helping to develop a World Bank-supported arsenic mitigation project.

36. Declines in available general resources for the country programme have placed additional importance on the raising of supplementary funds in order to maintain momentum. The 1998 flood has also been a major constraint. While it is too early to provide a thorough assessment of damage, the floods have extensively damaged infrastructure and agriculture, including the country's main rice crop and the major cash crop, jute. Damage is pervasive across the social sectors, with children and women most affected.

37. **Assessment of programme strategies: lessons learned.** The eight original strategies of the country programme have evolved in the course of implementation. The major current strategies are: operationalizing a rights-based approach to programmes that stresses the need to promote a national policy agenda informed by human rights principles; focusing on behavioural change through more intensive communication and advocacy initiatives; scaling up and mainstreaming innovative projects that have been evaluated and found to be successful, according to well-defined criteria; and strengthening partnerships with the Government, NGOs, civil society, donors and United Nations partners. These four strategies combine into a reaffirmation of the original overall goal of the country programme which is to support and catalyse the Government's national programme of action to achieve the national goals for

children inspired by the 1990 World Summit for Children.

38. The MTR noted two areas with regard to programme sustainability. First, there was agreement that in the remaining period, the country programme would increase efforts to assess the impact of capacity-building components. It was realized that sufficient information is yet not available to be able to make judgements on the efficacy of current capacity-building strategies. Second, the possibility of increasing government support of recurrent costs for some programmes will be explored. With regard to emerging programme areas, there will be an increased emphasis on birth registration, juvenile justice, communication activities on the Convention on the Rights of the Child aimed especially at reducing abuse, neglect and violence, and the building of national and subnational capacities for monitoring children's rights. Urgent measures to mitigate the effects of arsenic contamination will continue as a top priority.

39. **Country programme management plan.** The country programme structure has remained largely the same as approved in the country programme recommendation, with the addition of several sub-projects which result from the innovations introduced. Supplementary funding will be sought in due course to scale up these successful innovations. The country office underwent significant restructuring in 1997. Four subnational offices were closed and 18 smaller locations established without an increase in overall costs. The outcome is more intensive support at the local level than has been possible in the past. A planned realignment of staff will strengthen supervision of these field operations.

Major country programme evaluations

Regional evaluation of support to universal salt iodization

40. This evaluation covers UNICEF involvement in USI during 1993-1997. The production of iodized salt in the region has expanded, and public demand and consumption have increased. The proportion of households consuming iodized salt is highest in Bangladesh, Bhutan, Nepal and in the northern Indian States, while Maldives and Sri Lanka have lagged behind the rest of the region in initiating State-level action to move towards USI. UNICEF has supported advocacy and communication activities, factory quality assurance, field monitoring, evaluation, and the provision of mixing equipment, iodine substrate for mixing with salt and training.

41. Excluding support to India, the financial input was $6.25 million from general resources and $3.615 million in supplementary funding provided principally by the Canadian International Development Agency; National Committees for UNICEF of Austria, Canada, Italy and Japan; Kiwanis; and the Governments of Netherlands and Norway. The Government of India has provided $1.8 million to Nepal. UNICEF invested 199.3 months of professional staff time region-wide to USI, with a marginal decline in 1997.

42. Bangladesh, India and Pakistan now produce and iodize sufficient quantities of salt for national consumption. Sri Lanka can produce sufficient quantities of salt, but does not have full iodization capacity. Bhutan and Nepal import from India. Both support domestic iodization due to low iodine content in some supplies. While Maldives imports salt from various markets, the adequacy of the level of iodization is unknown. The reported percentages of iodized edible salt requirements available in each country are: in Bangladesh, 100 per cent in 1995 and 1996; in Bhutan, from 49 per cent in 1994 to 87 per cent in 1997; in India, 73 per cent in 1997; in Nepal, 100 per cent for 1993-1997; in Maldives, from 10 per cent in 1994 to 66 per cent in 1995; in Pakistan, from less than 5 per cent in 1994 to 25-30 per cent in 1997; and in Sri Lanka, from 10 per cent in 1994 to 40 per cent in 1996, dropping to 20 per cent in 1997. While these figures reflect some significant achievements, they may not always accurately reflect the adequacy of the salt iodization level. The proportion of households with access to iodized salt and regularly using it varies.

43. Some people do not have access to or choose not to use iodized salt, even where high percentages of salt iodization are found. In Bangladesh in the early 1990s, more than one half of households in two thirds of districts were not consuming iodized salt; and this remains the case in less than 25 per cent of districts today. Over one third of districts reported more than 80 per cent of households using iodized salt in 1998. Bhutan reports only one district with less than 80 per cent of households using iodized salt. In India, the availability of iodized salt at the household level varies from under 20 per cent in Tamil Nadu and Andra Pradesh to several states where every district reports more than 90 per cent availability. Maldives reports that 57 per cent of households use iodized salt, but adequacy is unknown. In Nepal, the 1996 Demographic and Health Survey supported by the United States Agency for International Development reported over 80 per cent of households with iodized salt. It is thought that a far northern mountainous area with a population of about 1 million does not receive iodized salt; supplementation in this area is effected with iodized

oil capsules. During 1998, UNICEF Nepal, in collaboration the Micronutrient Initiative, has supported a micronutrient survey that will provide details about the situation. In Pakistan, the use of iodized salt ranges from less than 20 per cent of households in Balochistan, Sindh and Punjab to just over one third in North-West Frontier Province. In Sri Lanka, inadequate iodization and inaccurate labelling of salt packages is common; a recent survey showed that only 26 per cent of households had adequately iodized salt.

44. In addition to expanding the distribution and use of iodized salt, in some areas, an increased capacity to iodize is needed. The quality of iodization in the factory is sometimes poor as short cuts may be taken during mixing. Increased efforts are needed to increase the numbers and effectiveness of government food inspectors charged with enforcing legislation regarding salt iodization and packaging. For sustainability, more Government and popular willingness to support USI financially is needed.

Community responses to sanitation risks, Pakistan

45. In collaboration with the United Nations Development Programme, the evaluation strategy for the 1996-1998 Pakistan country programme has facilitated one focused evaluative dialogue between programme stakeholder groups in civil society and the Government and among development partners per year. A network of evaluation stakeholders at national, provincial, district and village levels has been developed. This evaluation of community responses to sanitation risks is built upon the structure developed in 1997.

46. While trends show that sanitation coverage has increased, monitoring systems record increasing outbreaks of water-borne epidemics. The evaluation examined this fact in detail, aiming towards revised plans for the sanitation programme. The adequacy of latrines and sewage disposal channels were assessed, as were the behavioural aspects of health and hygiene practices.

47. The Planning Department chaired provincial evaluation steering committees with membership of line departments. Beyond the committees, several levels of administration and multiple partners were involved in the evaluation. The Federal Bureau of Statistics brings a representation of the public, including children, into the evaluation process through the random selection of sentinel communities. A review of programme progress and current information of the situation formed the basis for the design of methods of data collection. Data collection consisted of a household interview carried out in each of the households in the sentinel communities. More than 25,000 people were included in the sample population. Focus group discussions were held with the parents of 2,700 children under five years old in the sample.

48. The general findings were that one in five children were reported to have suffered from diarrhoea in the month preceding the survey. One half of the children surveyed were stunted. Diarrhoea was associated with greater poverty. Worm infestation was greater in rural areas. No significant difference was found between girls and boys for most diseases. A communication campaign led to an impact on awareness on advisable hygiene behaviour, especially in urban areas. The analysis concentrated on assessment of programme impacts, comparing experiences of programme beneficiaries with experiences of others, controlling for contextual factors. Since the results are context specific, varying from place to place, space precludes reporting on them here. Preliminary analysis was checked at the community level through focus group discussions. A total of 192 focus groups discussions were conducted.

49. The focus groups started the process of formulating potential improvements in programme design and potential actions. Six follow-up workshops with the broad network of evaluation stakeholders determined key, sustainable follow-up interventions. The evaluation strategy is a key aspect of the country programme focus district project. Thus, district-level officials, including the district administration and local-level line departments, were intensively involved in order to build their evaluation capacity.

50. The rights-based approach to programming has begun to create a new way of thinking among the evaluation stakeholders, which becomes especially prominent during the analysis and action workshops, bringing a more self-reliant attitude among programme stakeholders. The evaluation process is part of the overall country programme itself, helping to build a stronger movement for respect of human rights at the local level.

51. The second critical element of these evaluations is to bring a method and objectivity to decentralized planning, while encouraging a process of networking between different programme stakeholder groups. The strategy is one element in the general effort to build capacities for better governance, a key strategy for meeting the rights of vulnerable people through a process of increasing democratization. The provincial Bureaus of Statistics and the district administrations have benefited greatly from the capacity-building strategy.

52. By the end of the country programme (1996-1998), this evaluation strategy will have examined the three major areas of social investment in which UNICEF Pakistan is supporting. Beyond enhancing the process of improving existing plans, the evaluation will help to catalyse implementation and forge new partnerships to more fully address child rights.

Conclusion

53. The Regional Management Team (RMT) supports the important role of evaluation with a regional work plan task reviewed at each RMT meeting. Progress is being made with integrated monitoring and evaluation plans for the country programme. In-house technical capacity for evaluation has been strengthened with the creation of two new international posts with responsibility for managing the evaluation functions, one each in India and Pakistan. Progress continues in the development of a database linking indicators of programme process and outcome to geographic information systems now being adopted by other regions. Plans are being developed for UNICEF support to national evaluations that will be taking place in 2000 to report on progress with national development outcomes during the 1990s. Training in programme evaluation has been undertaken by staff in Bangladesh, Bhutan and India. Evaluation focal points and other staff, including country representatives, are now familiar with the American Evaluation Association Programme evaluation standards. Major evaluations are currently under way in the water and sanitation sector in Bangladesh, India and Pakistan and will be summarized in next year's report. An India country programme evaluation is being planned.